



15077

CERTIFICATE OF DEATH

1869

THE STATE OF NEW YORK, County of ...

DECEASED

may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12662

12637

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>			c. LENGTH OF STAY IN 1b <b>1 hr.-15 Min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall,</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hospital</b>				d. STREET ADDRESS <b>1 Main st.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marion</b> Middle <b>E.</b> Last <b>Chandler</b>				4. DATE OF DEATH Month <b>11</b> Day <b>20</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/16/21</b>	
9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>20</b> Hours <b>15</b> Min.		11. IF UNDER 24 HRS. Months <b>11</b> Days <b>20</b> Hours <b>15</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Fishery</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Jacob Chandler</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta Vorbringer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-16-7951</b>			
17. INFORMANT <b>(Wife) Lillian Chandler, Rock Hall, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>11/20/60</b> to <b>11/20/60</b> , that (I) (we) last saw the deceased alive on <b>11/20/60</b> , and that death occurred on <b>11/20/60</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. M. Gatewood</b>				22b. DATE <b>11/21/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Wm. M. Gatewood</b>	
22d. ADDRESS				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>11-23-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		23d. LOCATION (City, town, or county) (State) <b>Rock Hall Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin V. Williams - Chestertown</b>				25a. REC'D BY REGISTRAR <b>NOV 23 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
12663  
CERTIFICATE OF DEATH

12638

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Eleanor</b> Middle <b>Elenora</b> Last <b>Isabel Cook</b>				4. DATE OF DEATH Month <b>11</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/17/85</b>	
9. AGE (In years lost birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min. <b>75</b>		IF UNDER 24 HRS. Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min. <b>75</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Stephen B. Hickman</b>				14. MOTHER'S MAIDEN NAME <b>Mary R. Jewell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Harry Cook, 416 High St., Chestertown, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>332X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Post-operative State: Gall-stone - Ileus</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>11-8-1960</b> to <b>11-10-1960</b> , that (I) (we) last saw the deceased alive on <b>11-9-1960</b> , and that death occurred at <b>12:15 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A.T. KEEFE, M.D.</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>11-10-60</b>							
22c. PHYSICIAN'S NAME (Type) <b>A.T. KEEFE, M.D.</b> 22d. ADDRESS <b>CHESTERTOWN, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
23b. DATE THEREOF <b>11/13/1960</b>							
23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>							
23d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b> ADDRESS <b>Chestertown, Md.</b>							
25a. REC'D BY REGISTRAR <b>NOV 14 '60</b>							
25b. REGISTRAR'S SIGNATURE <b>Carling S. Kraus</b>							

- 44 -

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100-111-2100

For a more detailed discussion of the literature on the effects of the 1996 welfare reform, see the following:

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2002

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Form 10-10-10

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501-1724

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Level 1: 1711

Stephen B. Hickman

Harry Cook, the High School teacher, lives in the town.

02



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 12664  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

12639

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>		c. LENGTH OF STAY IN 1b <b>2 WEEKS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENT &amp; QUEEN ANNE'S</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>LEONARD</b> Last <b>DEATON</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 FEB. 1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>PHILLIP H. DEATON</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA BLAKE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>217013537</b>	
		17. INFORMANT Address <b>MRS. A. DEATON - CENTREVILLE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL ARTERIOSCLEROSIS &amp; THROMBOSIS</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MICROACINAR CARCINOMA OF PROSTATE; URINARY TRACT INFECTION</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b> <b>5 ± YEARS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 1959</b> to <b>14 NOV. 1960</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>14 Nov. 1960</b> , and that death occurred at <b>11:20 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J. Kent Young</b>		22b. DATE SIGNED <b>11/15/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. KENT YOUNG</b>		22d. ADDRESS <b>105 Chesterfield Ave. Centreville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/17/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BORRISVILLE</b>	23d. LOCATION (City, town, or county) (State) <b>Centreville Ind.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>		25a. REC'D BY REGISTRAR <b>NOV 28 1960</b>	
ADDRESS <b>C. Clark Hill Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

1903

MANUAL OF THE DEPARTMENT OF HEALTH  
OFFICE OF THE SECRETARY OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

18661



1. Name of deceased: John A. Smith

2. Sex: Male

3. Age: 45

4. Date of birth: Jan 15 1858

5. Place of birth: New York City

6. Date of death: Dec 10 1903

7. Place of death: Home

8. Cause of death: Heart Disease

9. Signature of physician: Dr. J. B. Jones

10. Signature of registrar: Wm. H. Brown

11. Signature of undertaker: Geo. E. White

12. Signature of coroner: Chas. F. Black

13. Signature of justice: John D. Green

14. Signature of clerk: John A. Smith

15. Signature of witness: John A. Smith







1943

CERTIFICATE OF DEATH

1943

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Registrar

Signature of Medical Officer

Signature of Coroner

Signature of Registrar

Signature of Medical Officer

Signature of Coroner

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filled in by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12666

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12641

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. LENGTH OF STAY IN 1b <b>26 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown (Lifetime)</b>			
f. STREET ADDRESS <b>117 Railroad Ave.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Eylett</b> Middle <b>M. R.</b> Last <b>Gland</b>				4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 23, 1896</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>6</b>		11. IF UNDER 24 HRS. Hours <b>12</b> Min. <b>00</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own &amp; private homes</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Edward Robinson</b>				14. MOTHER'S MAIDEN NAME <b>Harriett Berry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-07-6524</b>			
17. INFORMANT <b>Hospital records &amp; patient, Chestertown Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis (Primary site unknown, but probably Abdominal)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>5-6 months</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10/30</b> to <b>11/24</b> , that (I) (we) last saw the deceased alive on <b>11/24</b> 19 <b>60</b> , and that death occurred on <b>12 noon</b> in the causes and on the date stated above.							
22a. SIGNATURE <b>Robert W. Farr</b>				22b. DATE SIGNED <b>11/25/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Robert W. Farr</b>				22d. ADDRESS <b>Chestertown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/27/60</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Janes (col.) Cem.</b>				23d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bennett Woolley</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 29 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>							

GAUST

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 side, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12642

12676

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>NANCY</b> First <b>CAROLE</b> Middle <b>HEINEFIELD</b> Last		4. DATE OF DEATH Month <b>Nov.</b> Day <b>22</b> Year <b>1960</b>	
5. SEX <b>FEM</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 8 - 1944</b>
9. AGE (In years last birthday) <b>16</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES HEINEFIELD</b>		14. MOTHER'S MAIDEN NAME <b>LORRAINE GLENN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>CHARLES HEINEFIELD</b> Address <b>ROCK HALL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>345X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiplic sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 18, 1955</b> to <b>Nov. 22, 1960</b> , that I last saw the deceased alive on <b>Nov. 22, 1960</b> , and that death occurred at <b>6:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Robert C. Nitsch</b> M.D. <b>Rock Hall</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT C. NITSCH - MD. ROCK HALL MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 25</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Rock Hall MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b> ADDRESS <b>Church Hill, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 29 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

CERTIFICATE OF DEATH

12878

NAME OF DECEASED <i>Charles Howard</i>		SEX <i>Male</i>		AGE <i>40</i>	
DATE OF DEATH <i>April 12, 1924</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>None</i>	
EDUCATION <i>High School</i>		RELIGION <i>Methodist</i>		MARITAL STATUS <i>Married</i>	
BIRTH DATE <i>April 12, 1884</i>		BIRTH PLACE <i>Baltimore</i>		FATHER'S NAME <i>John Howard</i>	
MOTHER'S NAME <i>Anna Howard</i>		PREVIOUS ILLNESS <i>None</i>		PHYSICIAN'S NAME <i>Dr. J. H. Smith</i>	
DEATH CERTIFICATE NO. <i>12878</i>		REGISTRATION NO. <i>12878</i>		FILING DATE <i>April 15, 1924</i>	



12677

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tolchester Estates</u> c. LENGTH OF STAY IN lb <u>5 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Tolchester</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tolchester Estates</u> d. STREET ADDRESS <u>1 Tolchester</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hella</u> First <u>J</u> Middle <u>Hubbard</u> Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 9 1884</u> 9. AGE (In years lost birthday) <u>76</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1960</u>	
13. FATHER'S NAME <u>Charles H. Jones</u> 14. MOTHER'S MAIDEN NAME <u>Rebecca Reed</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>215-20-0222</u> 17. INFORMANT <u>Mrs. Charlotte Metzger</u> Address <u>Tolchester</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Nasopharynx</u> DUE TO (b) <u>146X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>146X</u> DUE TO (c) <u>146X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>146X</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 59</u> to <u>Nov 60</u> , that I last saw the deceased alive on <u>Oct 1960</u> , and that death occurred at <u>M.</u> from the cause and on the date stated above.			
ACTUAL SIGNATURE <u>William M. Lawrence</u> M.D.		ADDRESS (Street, city or town, state) <u>Rock Hall, Md.</u> DATE SIGNED <u>11/10/60</u>	
PHYSICIAN'S NAME (Type) <u>William M. Lawrence</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 11/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u> ADDRESS <u>Chesapeake Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 15 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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CERTIFICATE OF DEATH

15877

Name of Deceased  
Age  
Sex  
Race  
Date of Birth  
Date of Death

Place of Birth  
Cause of Death  
Disease or Injury  
Duration of Illness  
Place of Death

Signature of Physician  
Signature of Registrar  
Date of Registration

Signature of Medical Examiner  
Signature of Coroner

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

12644

12667

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Johnson</b> Last <b>Johnson</b>				4. DATE OF DEATH Month <b>11</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/1/80</b>	
9. AGE (In years lost birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>11</b> Days <b>14</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fisherman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Fishing</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Charles T. Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Phillips</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Don't know</b>				16. SOCIAL SECURITY NO. <b>Don't Know</b>		17. INFORMANT Address <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>10/10/60</b> to <b>11/14/60</b> , 19 <b>60</b> , that (II) (we) lost the deceased alive on <b>11/14/60</b> and that death occurred at <b>8:37</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>William M. Gatewood</b>				22b. DATE <b>11/15/60</b>		22c. SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>William M. Gatewood</b>				22d. ADDRESS <b>Chestertown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/17/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Willis Wells</b>				ADDRESS <b>Chestertown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 18 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

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STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

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Post Office

Chesapeake

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Chesapeake

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Kent's Green House Hospital

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12668

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

12645

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hospital</b>		d. STREET ADDRESS <b>17X-2</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Wesley</b> Last <b>Jones</b>		4. DATE OF DEATH <b>Nov. 5, 1960</b> Month <b>Nov.</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/00</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Jones</b>	
14. MOTHER'S MAIDEN NAME <b>Susie Williams</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>220-12-2346</b>		17. INFORMANT <b>John Wesley Jones</b> Address <b>Deceased</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary infarct</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-31</b> <b>60</b> to <b>11-5</b> <b>60</b> , that (I) (we) last saw the deceased alive on <b>11-5</b> <b>1960</b> , and that death occurred at <b>8p.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>A.C. Dick</b>		22b. DATE SIGNED <b>11-8-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A.C. Dick, M.D.</b>		22d. ADDRESS <b>Chestertown, Maryland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/9/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pondtown Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>near Crumpton, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel W. Wadley</b>		25a. REC'D BY REGISTRAR <b>NOV 14 '60</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>





12669

CERTIFICATE OF DEATH

12646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>			
c. LENGTH OF STAY IN 1b <b>39 days</b>				d. STREET ADDRESS <b>1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lita</b> Middle <b>Hartman</b> Last <b>Kelsey</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>9</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/4/86</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Hartman</b>				14. MOTHER'S MAIDEN NAME <b>Alice Alizes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Don't know</b>		17. INFORMANT <b>Lita H. Kelsey</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Granulocytic Leukemia</b> <b>204.1</b> DUE TO <b>chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured right hip surgically repaired</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>8-31-</b> , 19 <b>60</b> , to <b>11-9-</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>11-9-60</b> , at <b>12:30 P.M.</b> , and that death occurred at <b>12:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Harry Paul Ross</b>		M.D. <b>203 N. Queen St</b>		DATE SIGNED <b>11-9-60</b>		ADDRESS (Street, city or town, state) <b>Chestertown, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>HARRY PAUL ROSS</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THREPROF <b>Nov. 11, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cemete y</b>	
22d. LOCATION (City, town, or county) <b>Chestertown, Maryland</b>		22e. (State) <b>Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 14 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>		24c. (City or town, state) <b>Chestertown, Maryland</b>		24d. (County) <b>Md.</b>		24e. (State) <b>Md.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12647

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN lb <b>4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> d. STREET ADDRESS <b>518 Cannon Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Joseph</b> Last <b>Leonard</b>		4. DATE OF DEATH Month <b>11</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/11/91</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>9</b> Hours <b>10</b> Min.	11. IF UNDER 24 HRS. Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plant Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fertilizer Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Ellsworth Leonard</b>		14. MOTHER'S MAIDEN NAME <b>Mary Theiss</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-05-7254</b>	
17. INFORMANT <b>Mrs. Etta May Reed</b>		18. ADDRESS <b>518 Cannon Street, Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery disease</b> DUE TO (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b>Chronic emphysema, polyposis of colon, diverticulitis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic emphysema, polyposis of colon, diverticulitis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT OR UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-27</b> 19 <b>60</b> to <b>11-10</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>11-9</b> 19 <b>60</b> , and that death occurred at <b>4:30</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>A.C. Dick</b>		22b. DATE SIGNED <b>11-10-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A.C. Dick</b>		22d. ADDRESS <b>Chestertown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/13/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		25a. REC'D BY REGISTRAR <b>NOV 14 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kins</b>			

15870

CERTIFICATE OF DEATH

Plant Manager      Arthur      Joseph      Leonard      Kent

Male      White      x      3/11/21      09      11      10      20

Plant      Thomas Ellsworth Leonard      Henry Theiss      216 Cannon Street      U.S.A.

216 Cannon Street      U.S.A.

216 Cannon Street      U.S.A.

216 Cannon Street      U.S.A.

216 Cannon Street      U.S.A.

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216 Cannon Street      U.S.A.

216 Cannon Street      U.S.A.

216 Cannon Street      U.S.A.

216 Cannon Street      U.S.A.

12671

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

12648

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN lb <b>31 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> d. STREET ADDRESS <b>RFD#2 Box 110</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>(none)</b> Last <b>Lomax</b>		4. DATE OF DEATH Month <b>11</b> Day <b>11</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1895</b> <b>May 12 1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	9. AGE (In years last birthday) <b>65</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Lomax</b>		14. MOTHER'S MAIDEN NAME <b>Isabel Butcher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>215-20-0003</b>	
17. INFORMANT <b>Emma Lomax, (wife),</b>		Address <b>RFD#2, Box 110 Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>331X</b> DUE TO <b>??</b> (c) <b>??</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic sepsis due to infected decubitus ulcers, anaemia.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-10-60</b> to <b>11-11-60</b> , 19____, that (I) (we) last saw the deceased alive on <b>10-10-60</b> , 19____, and that death occurred on <b>11-11-60</b> , 19____, at <b>9a.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>A.C. Dick</b>		22b. DATE SIGNED <b>11-11-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A.C. Dick</b>		22d. ADDRESS <b>Chestertown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/15/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sandy Bottom Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>near - Chestertown, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Benneth Walker</b>		25a. REC'D BY REGISTRAR <b>NOV 16 '60</b>	
ADDRESS <b>Chestertown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

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Box 116 S. 65th St.

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George

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John L. Bunch

Isabel Butcher



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12672

12649

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Worton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eugene</b> Middle <b>Thornton</b> Last <b>Thornton</b>		4. DATE OF DEATH Month <b>11</b> Day <b>18</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/13/85</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.	11. IF UNDER 24 HRS. Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Norwood T. Thornton</b>		14. MOTHER'S MAIDEN NAME <b>Tabitha Jane Shaw</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>222-20-2070</b>	
17. INFORMANT <b>Eugene Thornton -Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial infarction</b> DUE TO (c) <b>Generalized arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gross hematuris (probably bladder carcinoma)</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-18</b> <b>1960</b> to <b>11-18</b> <b>1960</b> , that (I) ( <input checked="" type="checkbox"/> ) last saw the deceased alive on <b>11-18</b> <b>1960</b> and that death occurred at <b>10:20 pm</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>HARRY PAUL ROSS, M.D.</b>		22b. DATE SIGNED <b>11-19-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>HARRY PAUL ROSS, M.D.</b>		22d. ADDRESS <b>203 N. Queen St., Chestertown, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-22-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Nr. Chesapeake City, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>NOV 28 '60</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

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1884



CERTIFICATE OF DEATH

1884



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12673

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne Hospital (1 day)</b>		e. STREET ADDRESS <b>Rural</b>	
3. NAME OF DECEASED (Type or print) First <b>Lucille</b> Middle <b>F.</b> Last <b>Turner</b>		4. DATE OF DEATH <b>Nov. 9, 1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/19/1907</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. Foulks</b>		14. MOTHER'S MAIDEN NAME <b>Mary Foley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-24-2366</b>	
17. INFORMANT <b>Robert Turner</b>		Address <b>Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock due to injuries sustained in auto accident 11/8/60</b> DUE TO (b) <b>Fractured ribs - rt with hemothorax, Ruptured spleen</b> DUE TO (c) <b>Was in a car - locomotive grade crossing collision. In shock on arrival hospital, Splenectomy 300 ccblood</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>rt thorax. Never aroused from shock.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>see above Auto collision with train.</b>	
20c. TIME OF INJURY <b>5:30 p.m. 11/8 1960</b>		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While of work <input type="checkbox"/> Not while of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>grade crossing</b>		20f. (City or town) <b>Ridgely, Md.</b> (County) <b>Caroline</b> (State) <b>Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R. W. Farr</b>		DATE SIGNED <b>Nov. 10, 1960</b>	
EXAMINER'S NAME (Type) <b>Robert W. Farr</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 12, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		22d. LOCATION (City, town, or county) <b>Chestertown, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b> ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 14 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles L. Harris</b>	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED		DATE	
NAME		AGE	
SEX		RACE	
BIRTH		PLACE OF BIRTH	
MARRIAGE		MILITARY SERVICE	
OCCUPATION		EDUCATION	
RELIGION		MANNER OF DEATH	
CAUSE OF DEATH		MORBIDITY	
SYMPTOMS		TREATMENT	
HISTORY		FAMILY HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
POSTMORTEM EXAMINATION		PATHOLOGICAL FINDINGS	
MICROSCOPIC FINDINGS		BACTERIOLOGICAL FINDINGS	
HISTOCHEMICAL FINDINGS		IMMUNOLOGICAL FINDINGS	
CYTOLOGICAL FINDINGS		GENETIC FINDINGS	
TOXICOLOGICAL FINDINGS		ANTHROPOLOGICAL FINDINGS	
SOCIOLOGICAL FINDINGS		PSYCHOLOGICAL FINDINGS	
PSYCHIATRIC FINDINGS		NEUROLOGICAL FINDINGS	
ENTOMOLOGICAL FINDINGS		FORENSIC FINDINGS	
LEGAL FINDINGS		OTHER FINDINGS	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 4 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12678 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12651

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Worton</b>				c. LENGTH OF STAY IN lb <b>1 day</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>near Coleman's Corner RD Worton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>			
3. NAME OF DECEASED (Type or print) <b>Cramer Bennie Vaughn</b>				d. STREET ADDRESS <b>1542 N. Payson St.</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH <b>Nov. 16, 1960</b>		5. SEX <b>male</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>June 16, 1912</b>		9. AGE (In years last birthday) <b>48</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Peter Vaughn</b>		14. MOTHER'S MAIDEN NAME <b>Roxanna Vinson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>215-09-5513</b>		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple shot gun pellet injuries involving rt. chest &amp; anterior chest (30 to 100)</b> DUE TO (b) <b>a few min.</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shot accidentally while hunting</b>		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) <b>Shot accidentally while hunting</b>		20c. TIME OF INJURY Month, Day, Year <b>2:30 p.m. 11/16 60</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) (County) (State) <b>Worton Kent Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. ACTUAL SIGNATURE <b>Robert W. Farr</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/21/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Carver Mem. Park Laurel</b>	
22d. LOCATION (City, town, or country) (State) <b>md.</b>		23. FUNERAL DIRECTOR <b>Wilmington A. Phillips</b>		23a. REC'D BY REGISTRAR <b>NOV 22 '60</b>		23b. REGISTRAR'S SIGNATURE <b>Arthur A. Thomas</b>	



(M)

June 16, 1912

North Carolina

Walter Vernon

Robert Taylor

10-1-12

Multis shot and bullet injuries resulting  
in chest & anterior chest (30 to 100)

Shot accidentally while hunting

2:30 PM 11/10 60

Walter

Robert

K



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>12674</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</span> <span>12652</span> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Kent</b> <b>MARYLAND</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Still Pond</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hospital</b>						d. STREET ADDRESS <b>1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Angie</b> Middle <b>Lina</b> Last <b>Wilmer</b>						<b>4. DATE OF DEATH</b> Month <b>11</b> Day <b>21</b> Year <b>19 60</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>2/16/86</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>74</b>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Alexander Piner</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Katherine Banner</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>(Husband) John H. Wilmer, Still Pond, Md.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>491X</b> <b>Broncho Pneumonia</b> <b>several days</b> IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. 19				<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from 11/21 1960 to 11/21 1960, that (I) (we) last saw the deceased alive on 11/21 1960, and that death occurred at 9 A.M. from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <i>Robert W. Farr</i>						<b>22b. ADDRESS</b> <b>Chestertown, Md.</b>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Robert W. Farr</b>						<b>22d. ADDRESS</b> <b>Chestertown, Md.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>11/26/60</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Still Pond (Colored)</b>			<b>23d. LOCATION (City, town, or county)</b> (State) <b>Still Pond. Md.</b>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Spencer W. W. W.</i>						<b>25a. REC'D BY REGISTRAR</b> <b>NOV 28 1960</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hume</i>			

BP

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bop5 11132

YAD I

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Robert W. Zarek